FCI McKEAN, PA 16701 814-362-8900

RX400069481 T. MONTGOMERY 05/19/98
BAKER,DARRYL 19613-039
TAKE 1 TABLET 3 TIMES A DAY WITH FOOD

IBUPROFEN 800 MG TABLET #9
CG 0 REFILLS EXPIRES 05/23/98

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400080567 W. FLATT 02/25/99
BAKER,DARRYL 19613-039
TAKE 1 TABLET 3 TIMES A DAY WITH FOOD

IBUPROFEN 800 MG TABLET #21
CG 1 REFILLS EXPIRES 04/26/99

Pharmacy Services
FCI McKEAN, PA 16701 814-362-8900

RX400085431 W. FLATT 08/09/99
BAKER,DARRYL 19613-039
TAKE 1 OR 2 TABLETS 3 TIMES A DAY AS NEEDED
WITH FOOD

IBUPROFEN 400 MG TABLET #15
CG 1 REFILLS EXPIRES 09/18/99

PROBLEM LIST

	ACTIVE PROBLEMS	DATE NOTED	INACTIVE/RESOLVED PROBLEMS	DATE IF RESOLVED
1.	NKA	10-3-95		
2	Hx Poly substance abuse	10-3-95		
3.	2/29/04 / NKDA (φ Food, φ Environment)			
4/15/04	(L) orbital Fx probably 2/27/04 mild entrapment (L) inferior rectus muscle –			
	6/24/04 / NKDA φ Food (+) Environment – ? Dust/mold/smoke			
	6/24/04 Chronic Folliculitis			
01/10/05	CAR I			
8-11-05	Hx (L) orbital fracture			

NAME
BIRTH DATE
SS/REG. NO.

BAKER
DARRYL ORRIN 19613-039
B/M/O/06-30-1962
HT/602 WT/190 HR/BK EY/BN
CUSTODY/

9)

PROBLEM LIST

Dec 2012 000096

Medication Summary Sheet

Chronic Conditions

Ord.Date 01/29/04 — BAKER, DARRYL ORRIN — S. LABROZZI
19613-039 — (2)Refills
Exp.Date 04/27/04
TAKE ONE TABLET FOUR TIMES DAILY FOR 10 DAYS , THEN TAKE ONE TABLET TWICE DAILY
Rx # 162674
ERYTHROMYCIN DELAYED RELEASE 500 MG TAB #40

Ord.Date 01/29/04 — BAKER, DARRYL ORRIN — S. LABROZZI
19613-039 — (0)Refills
Exp.Date 02/17/04
TAKE ONE CAPSULE THREE TIMES DAILY AS NEEDED FOR ITCHING
Rx # 162675
DIPHENHYDRAMINE 25 MG CAP #15

Ord.Date 01/29/04 — BAKER, DARRYL ORRIN — S. LABROZZI
19613-039 — (0)Refills
Exp.Date 02/27/04
TAKE ONE TABLET FOUR TIMES DAILY AS NEEDED FOR PAIN
Rx # 162676
IBUPROFEN 400 MG TAB #30

Ord.Date 03/11/04 — BAKER, DARRYL ORRIN — H. BEAM,MD
19613-039 — (0)Refills
Exp.Date 03/30/04
TAKE ONE CAPSULE FOUR TIMES DAILY
Rx # 164649
CEPHALEXIN 500 MG CAP #28

Ord.Date 03/11/04 — BAKER, DARRYL ORRIN — H. BEAM,MD
19613-039 — (0)Refills
Exp.Date 03/17/04
INSTILL 2 DROPS IN THE LEFT EYE FOUR TIMES DAILY FOR 5 DAYS
Rx # 164650
SULFACETAMIDE OPHTHALMIC SOLN 10% ML #1

Ord.Date 04/01/04 — BAKER, DARRYL ORRIN — H. BEAM,MD
19613-039 — (0)Refills
Exp.Date 04/30/04
TAKE ONE TABLET EACH DAY
Rx # 165404
KETOCONAZOLE 200 MG TAB #21

Ord.Date 06/24/04 — BAKER, DARRYL ORRIN — R. PIOTROWSKI
19613-039 — (3)Refills
Exp.Date 09/21/04
INHALE 2 SPRAYS IN EACH NOSTRIL TWICE DAILY
Rx # 169204
FLUNISOLIDE NASAL SPRAY 0.025% ML #1

Ord.Date 06/24/04 — BAKER, DARRYL ORRIN — R. PIOTROWSKI
19613-039 — (0)Refills
Exp.Date 07/07/04
TAKE ONE TABLET THREE TIMES DAILY FOR 10 DAYS
Rx # 169203
ERYTHROMYCIN DELAYED RELEASE 500 MG TAB #30

Acute Conditions

Ord.Date 03/31/03 — BAKER, DARRYL ORRIN — B. SAYLOR
19613-039 — (0)Refills
Exp.Date 04/06/03
TAKE ONE TABLET FOUR TIMES DAILY UNTIL FINISHED
Rx # 145517
PENICILLIN VK 250 MG TAB #28

Ord.Date 04/01/03 — BAKER, DARRYL ORRIN — H. BEAM,MD
19613-039 — (0)Refills
Exp.Date 04/07/03
TAKE ONE CAPSULE FOUR TIMES DAILY UNTIL FINISHED
Rx # 145586
CEPHALEXIN 500 MG CAP #28

Ord.Date 04/01/03 — BAKER, DARRYL ORRIN — H. BEAM,MD
19613-039 — (2)Refills
Exp.Date 06/26/03
APPLY TO AFFECTED AREA 2 TIMES A WEEK AS DIRECTED **EXTERNAL USE ONLY**
Rx # 145587
SELENIUM SULFIDE LOTION 2.5% ML #1

Ord.Date 04/11/03 — BAKER, DARRYL ORRIN — H. BEAM,MD
19613-039 — (0)Refills
Exp.Date 04/30/03
TAKE ONE CAPSULE FOUR TIMES DAILY
Rx # 146355
CEPHALEXIN 500 MG CAP #40

Ord.Date 04/11/03 — BAKER, DARRYL ORRIN — H. BEAM,MD
19613-039 — (2)Refills
Exp.Date 07/09/03
APPLY TO AREA, LATHER, THEN RINSE. USE 2 TIMES WEEKLY
Rx # 146356
SELENIUM SULF LOTION 2.5% ML #1

Ord.Date 03/31/04 — BAKER, DARRYL ORRIN — H. BEAM,MD
19613-039 — (0)Refills
Exp.Date 04/13/04
TAKE ONE TABLET FOUR TIMES DAILY
Rx # 165338
PENICILLIN VK 500 MG TAB #40

Ord.Date 04/09/04 — BAKER, DARRYL ORRIN — H. BEAM,MD
19613-039 — (0)Refills
Exp.Date 04/22/04
TAKE ONE TABLET FOUR TIMES DAILY
Rx # 165811
PENICILLIN VK 500 MG TAB #40

Ord.Date 04/22/04 — BAKER, DARRYL ORRIN — H. BEAM,MD
19613-039 — (0)Refills
Exp.Date 05/05/04
TAKE ONE TABLET FOUR TIMES DAILY
Rx # 166299
PENICILLIN VK 500 MG TAB #40

BP-S619.060 **IMMUNIZATION RECORD** CDFRM
AUG 93
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TETANUS TOXOIDS

DATE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION

TUBERCULIN TESTS

DATE GIVEN	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER/ INSTITUTION	DATE READ	RESULTS (MM)	READ BY
10-1-97	Connaught	2460-11	11-98	(L) FA	5TU ID	C. Rymer RN FCI McKean	10/3/97	0 x cm	[illegible]
10-6-98	Connaught	2480-11	7/99	(L) FA	0.1 ID	McKean/ Georgy	10/8/98	0 x 0	[illegible]
10/12/99	Connaught	2506-11	5/5/99	(L) FA	5TU ID	C. Rymer RN FCI McKean	10/14/99	0 x 0	[illegible]
9/27/00	CONNAUGHT	C0151AA	10/6/01	(R) F.A.	0.1cc ID	[illegible] EMT-P/ FCI Loretto	9/29/00	Ø mm	[illegible]
9-12-01	Connaught	C0619AA	1-2-02	(R) FA	0.1ml ID	[illegible] PAC/ FCI [illegible]	9/14/01	0 mm	[illegible]
9/17/02	Aventis	C0984AA	5/14/04	(L) FA	0.1cc ID	[illegible]	9/19/02	0 x 0	[illegible]
9/9/03	Park	[illegible]	5/04	(L) FA	0.1cc ID	[illegible]	9-11-03	0 x 0	[illegible]
10/15/04	AVENTIS	C1336AA	01/05	LFA	0.1ml ID	FSL ELKTON	10/18/04	0 x 0	[illegible]
[illegible]	[illegible]	[illegible]	05/07	(L) FA	0.1cc ID	[illegible]	[illegible]	0 [illegible]	[illegible]

Patient Identification
(Name, Reg #)

(This form may be replicated via WP)

Darryl Baker
14613-039

000098

HEALTH RECORD — IMMUNIZATION RECORD

All entries in ink to be made in block letters

VACCINATION AGAINST SMALLPOX *(Number of previous vaccination scars)*

	DATE	ORIGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						

YELLOW FEVER VACCINE

	DATE	ORIGIN	BATCH NUMBER	STATION	PHYSICIAN'S NAME
1					
2					
3					

TYPHOID VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

TETANUS-DIPHTHERIA TOXOIDS

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1	11/8/95	0.5 cc	D. KAPEL, FMG PA	4			
2				5			
3				6			

CHOLERA VACCINE

	DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME
1			4			7		
2			5			8		
3			6			9		

PATIENT'S IDENTIFICATION *(Mechanically Imprint, Type or Print)*:

Darryl Baker
19613-039

Patient's Name—last, first, middle initial; Sex; Age or Year of Birth; Relationship to Sponsor; Component/Status; Department/Service.

Sponsor's Name—last, first, middle initial; Rank/Grade; SSN or Identification Number; Organization.

000099

601-105

IMMUNIZATION RECORD

Standard Form 601—October 1975 (Rev.)
General Services Administration & Interagency Committee on Medical Records

ORAL POLIOMYELITIS VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

INFLUENZA VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

OTHER IMMUNIZATIONS

	DATE	TYPE	DOSE	PHYSICIAN'S NAME		DATE	TYPE	DOSE	PHYSICIAN'S NAME
1					5				
2					6				
3					7				
4					8				

SENSITIVITY TESTS *(Tuberculin, etc.)*

	DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
1	10/4/55	PPD	0.1 cc	ID	0.0 mm	Mc Doty
2	10/8/96	PPD	0.1	ID	0X0 mm (-)	D. OLSON, MD
3						
4						
5						

REMARKS:

THIS RECORD IS ISSUED IN ACCORDANCE WITH ARTICLE 99, WHO SANITARY REGULATION NO. 2.

*U.S. Government Printing Office: 1993 — 342-199/50251

HEALTH RECORD

IMMUNIZATION RECORD

All entries in ink to be made in block letters

VACCINATION AGAINST SMALLPOX *(Number of previous vaccination scars)*

	DATE	ORIGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						

YELLOW FEVER VACCINE

	DATE	ORIGIN	BATCH NUMBER	STATION	PHYSICIAN'S NAME
1					
2					
3					

TYPHOID VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

TETANUS-DIPHTHERIA TOXOIDS

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

CHOLERA VACCINE

	DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME
1			4			7		
2			5			8		
3			6			9		

PATIENT'S IDENTIFICATION *(Mechanically Imprint, Type or Print)*:

FCI, MILAN, MICHIGAN

Baker Daryl

-104 19613-039

Patient's Name—last, first, middle initial; Sex; Age or Year of Birth; Relationship to Sponsor; Component/Status; Department/Service

Sponsor's Name—last, first, middle initial; Rank/Grade; SSN or Identification Number; Organization.

IMMUNIZATION RECORD
Standard Form 601 October 1975
General Services Administration and
[illegible]

000101

ORAL POLIOVIRUS VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIANS NAME
1				3			
2				4			

INFLUENZA VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

OTHER IMMUNIZATIONS

	DATE	TYPE	DOSE	PHYSICIAN'S NAME		DATE	TYPE	DOSE	PHYSICIAN'S NAME
1					5				
2					6				
3					7				
4					8				

SENSITIVITY TESTS *(Tuberculin, etc.)*

	DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
1	6-9-95	PPD	0.1cc	ID	0.0mm	M Doty
2						
3						
4						
5						

REMARKS:

THIS RECORD IS ISSUED IN ACCORDANCE WITH ARTICLE 99, WHO SANITARY REGULATION NO. 2.

☆U.S.GI)-0-311-153/5507

000102

HEALTH RECORD

IMMUNIZATION RECORD

All entries in ink to be made in block letters

VACCINATION AGAINST SMALLPOX *(Number of previous vaccination scars)*

	DATE	ORIGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						

YELLOW FEVER VACCINE

	DATE	ORIGIN	BATCH NUMBER	STATION	PHYSICIAN'S NAME
1					
2					
3					

TYPHOID VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

TETANUS-DIPHTHERIA TOXOIDS

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

CHOLERA VACCINE

	DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME
1			4			7		
2			5			8		
3			6			9		

PATIENT'S IDENTIFICATION *(Mechanically Imprint, Type or Print)*:

Baker Darryl
19613-039

Patient's Name—last, first, middle initial; Sex; Age or Year of Birth; Relationship to Sponsor; Component/Status; Department/Service.

Sponsor's Name—last, first, middle initial; Rank/Grade; SSN or Identification Number; Organization.

601-105

IMMUNIZATION RECORD

Standard Form 601—October 1975 (Rev.)
General Services Administration & Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505

000103

ORAL POLIOVIRUS VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

INFLUENZA VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

OTHER IMMUNIZATIONS

	DATE	TYPE	DOSE	PHYSICIAN'S NAME		DATE	TYPE	DOSE	PHYSICIAN'S NAME
1					5				
2					6				
3					7				
4					8				

SENSITIVITY TESTS *(Tuberculin, etc.)*

	DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
1	10-4-95	PPD	0.1cc	ID	0.0mm	M.D.
2						
3						
4						
5						

REMARKS:

000104

THIS RECORD IS ISSUED IN ACCORDANCE WITH ARTICLE 99, WHO SANITARY REGULATION NO. 2.

* U.S.GOVERNMENT PRINTING OFFICE 1995 390-110/09111

REPORT OF MEDICAL EXAMINATIOI

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
BAKER, Darryl		19413-039
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	5. PURPOSE OF EXAMINATION: FOOD HANDLERS' PHYSICAL	6. DATE OF EXAMINATION: 7/13/00

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
M	BLK	MILITARY	CIVILIAN		

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
FCI LORETTO	

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
	18. HEAD, FACE, NECK AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71)	
	23. DRUMS (Perforation)	
✓	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (Equality and reaction)	
	27. OCULAR MOTILITY (Associated parallel movements nystagmus)	
✓	28. LUNGS AND CHEST (Include breasts)	
	29. HEART (Thrust, size, rhythm, sounds)	
	30. VASCULAR SYSTEM (Varicosities,etc.)	
	31. ABDOMEN AND VISCERA (Include hernia)	
	32. ANUS AND RECTUM (Hemorrhoids, Fistulas) (Prostate, if indicated)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (Strength, range of motion)	
	36. FEET	
	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
✓	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (Equilibrium tests under item 72)	
	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

The following is a FOOD HANDLERS' PHYSICAL which determines if and inmate is medically cleared, free of infectious disease, and is able to work in Food Service. It determines if the inmate is free from: Acute or chronic inflammatory conditions of the respiratory system; Acute or chronic infectious skin diseases; Acute or chronic intestinal infection and/or communicable disease.

Chest clear to A&P
Sclera clear Bilat
Heart RRR S murmurs.
Skin S rashes or lesions

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable Teeth (0 / 2 / 3 / 31 / 30 / 0) — Non-restorable teeth (1 / 2 / 3 / 32 / 31 / 30 / /) — Missing Teeth (1 / 2 / 3 / 32 / 31 / 30 / x) — Replaced by Dentures (x x x / 1 2 3 / 32 31 30 / x x x) — Fixed Partial dentures ((1 x) / 32 31 30 / (x))

RIGHT 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY	46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN / D. MICROSCOPIC	
C. SUGAR	

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

000105

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD: ☐ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	56. TEMPERATURE

57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)				
A. SITTING	SYS. / DIAS.	B. RECUMBENT	SYS. / DIAS.	C. STANDING (5 min.)	SYS. / DIAS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION	
RIGHT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

62. HETEROPHORIA (Specify distance)

ES*	EX*	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

63. ACCOMMODATION		64. COLOR VISION (Test used and result)	65. DEPTH PERCEPTION (Test used and score)	UNCORRECTED
RIGHT	LEFT			CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (Test used and score)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING			71. AUDIOMETER									72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)
RIGHT WV	/15 SV	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV	/15 SV	/15	RIGHT									
			LEFT									

73 NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

PPD Status:

Date: 10/12/99 **Results:** 0 mm

CXR: (If applicable)

Date: _____ **Results:** _____

RPR Status:

Date: 4/14/95 **Results:** NR

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

The patient is able to work in Food Service: Yes ✓ **No** _____

The inmate received patient education and was advised to keep hands clean at all times while handling food, wear protective gloves when handling food, wash hands after using restroom and to report any suspicious rash or skin lesions, fever, night sweats or productive coughing to Health Services Staff. The patient voiced understanding of above instructions.

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (Check)

A. ☐ IS QUALIFIED FOR

B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

A	B	C	E

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
MIDDLEKAUFF PA-C	
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)	SIGNATURE
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
Baker, Darryl		19613-039
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
X 4219 Winona Flint Mi. 48504	A+O	11-8-95

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
M	X Black			BOP/DOJ	FCI McKean

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
X 6-30-62	X Flint, Mi.	X Robbie Baker mother

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
FCI McKean, Bradford, PA	

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
✓	18. HEAD, FACE, NECK AND SCALP	
✓	19. NOSE	
✓	20. SINUSES	
✓	21. MOUTH AND THROAT	
✓	22. EARS—GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71)	
✓	23. DRUMS (Perforation)	
✓	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
✓	25. OPHTHALMOSCOPIC	
✓	26. PUPILS (Equality and reaction)	
✓	27. OCULAR MOTILITY (Associated parallel movements nystagmus)	
✓	28. LUNGS AND CHEST (Include breasts)	
✓	29. HEART (Thrust, size, rhythm, sounds)	
✓	30. VASCULAR SYSTEM (Varicosities,etc.)	
✓	31. ABDOMEN AND VISCERA (Include hernia)	
✓	32. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Prostate, if indicated)	
✓	33. ENDOCRINE SYSTEM	
✓	34. G-U SYSTEM	
✓	35. UPPER EXTREMITIES (Strength, range of motion)	
✓	36. FEET	
✓	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	✓ abd. on (R) side,
✓	40. SKIN, LYMPHATICS	
✓	41. NEUROLOGIC (Equilibrium tests under item 72)	
✓	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable Teeth: 1 2 3 / 32 31 30 — 0 over 2, 0 under 31
Non-restorable teeth: 1 2 3 / 32 31 30 — / over 2, / under 31
Missing Teeth: 1 2 3 / 32 31 30 — x over 2, x under 31
Replaced by Dentures: x x x / 32 31 30 / x x x
Fixed Partial dentures: (x) / 1 2 3 / 32 31 30 / (x)

RIGHT																	LEFT
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY		46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN	D. MICROSCOPIC	
C. SUGAR		

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

000107

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD	56. TEMPERATURE
6'2"	202	black	brown	☐ SLENDER ☐ MEDIUM ☒ HEAVY ☐ OBESE	97-8

57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)				
A. SITTING	SYS. 120 / DIAS. 84	B. RECUMBENT	SYS. / DIAS.	C. STANDING (5 min.)	SYS. / DIAS.	A. SITTING 86	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.

59. DISTANT VISION	60. REFRACTION	61. NEAR VISION
RIGHT 20/ 20 CORR. TO 20/	BY S. CX	CORR. TO BY
LEFT 20/ 20 CORR. TO 20/	BY S. CX	CORR. TO BY

62. HETEROPHORIA (Specify distance)

ES°	EX°	R.H.	L.H.	PRISM DIV.	PRISM CONV CT	PC	PD

63. ACCOMMODATION	64. COLOR VISION (Test used and result)	65. DEPTH PERCEPTION (Test used and score)	UNCORRECTED
RIGHT WNL LEFT	NT		CORRECTED

66. FIELD OF VISION	67. NIGHT VISION (Test used and score)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING	71. AUDIOMETER									72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)
RIGHT WV /15 SV /15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV /15 SV /15	RIGHT									
	LEFT									

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

1) (-) H/O significant Hx,

2) Self. — Hx. — nothing significant
Car accident 2 liver lacerations when 8th in childhood

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

> Some blood in stool, x 2 mths - - - red at the end of defecation

33 y.o. ♂ Ethn otherwise,

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

Occult Stool x 3 w,

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (Check)

A. ☒ IS QUALIFIED FOR
B. ☐ IS NOT QUALIFIED FOR

Applies

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

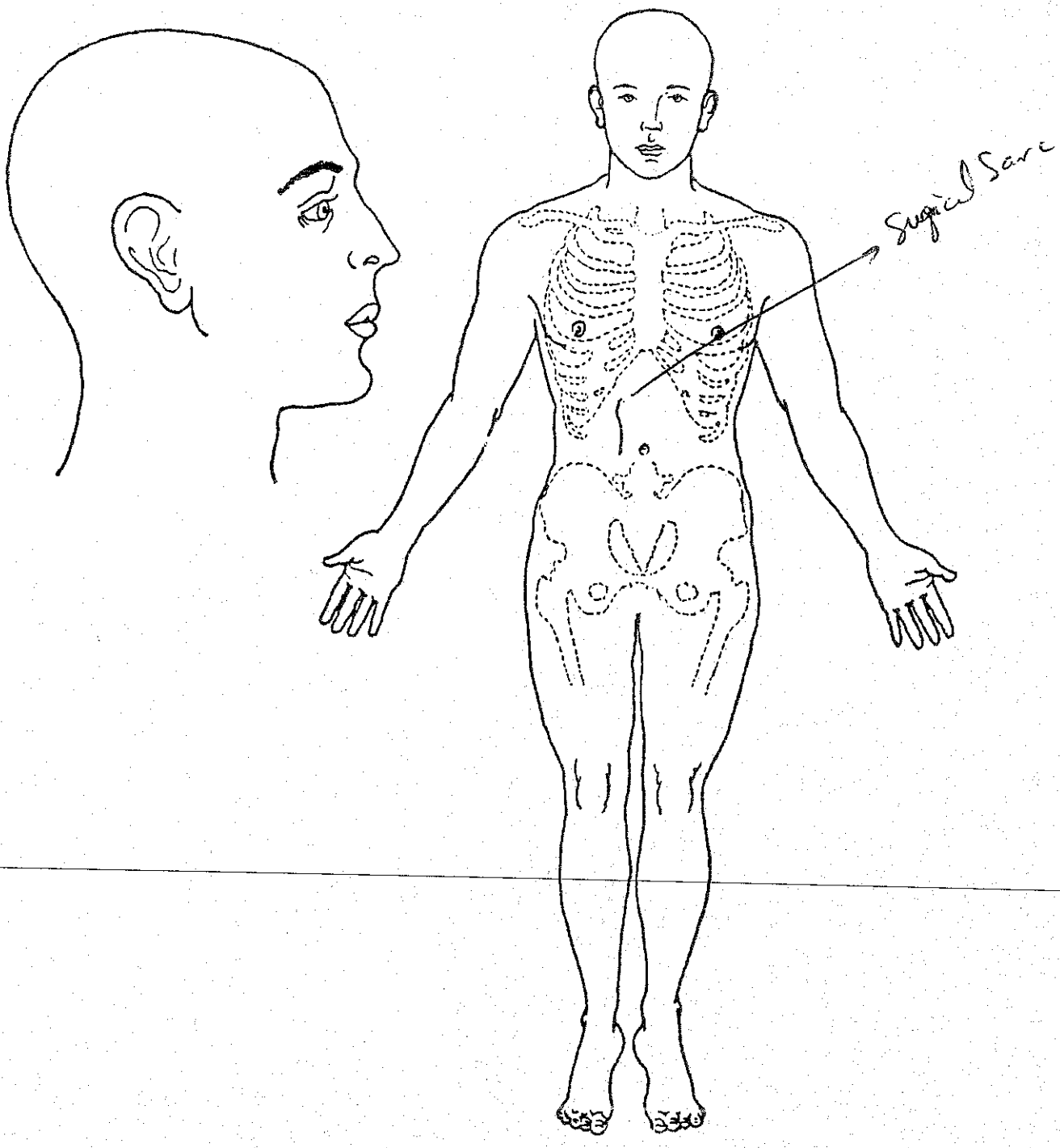
79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
D.K. PEL, FMG PA	
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
D. OLSON ML	
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (If Optional)	SIGNATURE
CLINICAL DIRECTOR	
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

☆U.S. GOVERNMENT PRINTING OFFICE: 1993-342-199/50177

531-110

NSN 7540-00-634-4274

MEDICAL RECORD | **ANATOMICAL FIGURE**



PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility.)*

REGISTER NO. 19613-039

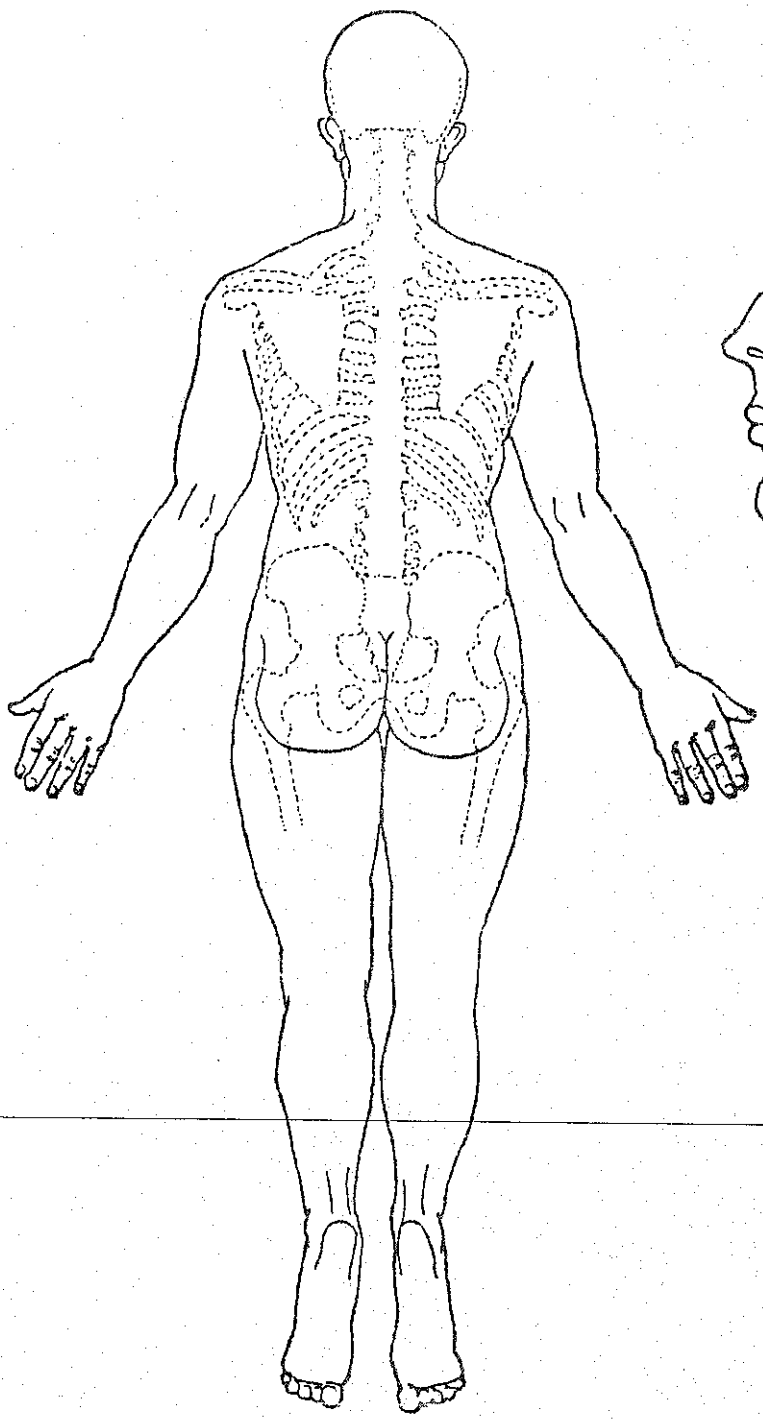
WARD NO.

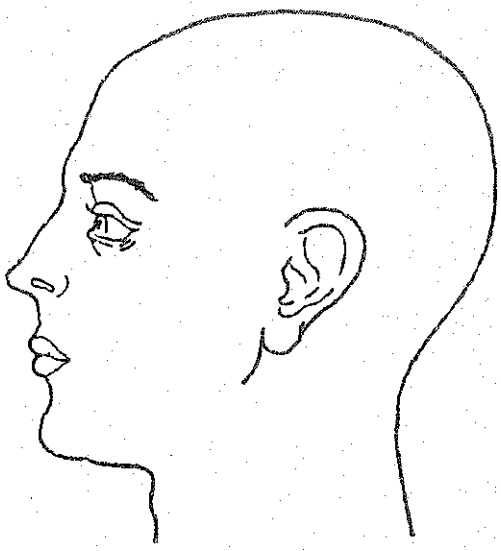
Darryl Baker

ANATOMICAL FIGURE

STANDARD FORM 531 (Rev. 4-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

000109





000110

U.S. Department of Justice

Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
[illegible] DEAN DARRIL	#19613-039

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Busy intake	8-12-4	FCI ELKTON

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
		Lived with anyone who had tuberculosis
		Coughed up blood
		Bled excessively after injury or tooth extraction
		Attempted suicide
		Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
✓		Wear glasses or contact lenses
		Have vision in both eyes
		Wear a hearing aid
		Stutter or stammer habitually
		Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever
			Rheumatic fever
✓			Swollen or painful joints
✓			Frequent or severe headache
✓			Dizziness or fainting spells
			Eye trouble
			Ear, nose, or throat trouble
			Hearing loss
			Chronic or frequent colds
✓			Severe tooth or gum trouble
			Sinusitis
			Hay Fever
			Head injury
			Skin diseases
			Thyroid trouble
✓			Tuberculosis
✓			Asthma
✓			Shortness of breath
✓			Pain or pressure in chest
✓			Chronic cough
			Palpitation or pounding heart
			Heart trouble
			High or low blood pressure
			Cramps in your legs
			Frequent indigestion
			Stomach, liver, or intestinal trouble
			Gall bladder trouble or gallstones
			Jaundice or hepatitis

YES	NO	DON'T KNOW	(Check each item)
			Adverse reaction to serum drug or medicine
			Broken bones
			Tumor, growth, cyst, cancer
			Rupture/hernia
			Piles or rectal disease
			Frequent or painful urination
			Bed wetting since age 12
			Kidney stone or blood in urine
			Sugar or albumin in urine
			VD—Syphilis, gonorrhea, etc.
✓			Recent gain or loss of weight
			Arthritis, Rheumatism, or Bursitis
			Bone, joint or other deformity
			Lameness
			Loss of finger or toe
			Painful or "Trick" shoulder or elbow
			Recurrent back pain
			"Trick" or locked knee
			Foot trouble
			Neuritis
			Paralysis (include infantile)

YES	NO	DON'T KNOW	(Check each item)
			Epilepsy or fits
			Car, train, sea or air sickness
			Frequent trouble sleeping
			Depression or excessive worry
			Loss of memory or amnesia
			Nervous trouble of any sort
			Periods of unconsciousness
			Have you ever had homosexual contact?
			Been exposed to AIDS
			Alcohol Use (Excessive)
			Drug Use/Addiction
			Marijuana
			Cocaine
			Heroin
			L.S.D.
			Amphetamines
			Others: (Specify)
			Alcohol or drug Withdrawal Problems

10. FEMALES ONLY HAVE YOU EVER

			Been treated for a female disorder
			Had a change in menstrual pattern
			ARE YOU PREGNANT
			SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

GENERAL MOTORS

12. ARE YOU (Check one) 000111

☒ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
		13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
		B. Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
		C. Inability to assume certain positions.			
		D. Other medical reasons *(If yes, give reasons.)*			20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
		14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
		15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
		16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13–22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE Darryl BAKER

SIGNATURE Darryl Baker

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ✓ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ✓

GENERAL POPULATION ____ YES ✓ NO ____

TYPE AND EXTENT OF LIMITATION ____

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

Ø Lice
Ø Scabies

000112

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Gary Bullock Physician Assistant	8-12-04	G Bullock PA	

REVERSE

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
BAKER DARYL ORIN	19613-039

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Intake	7/7/04	MDE Bro

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

" Good "

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
✓		Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to serum drug or medicine		✓		Epilepsy or fits
	✓		Rheumatic fever		✓				✓		Car, train, sea or air sickness
	✓		Swollen or painful joints		✓		Broken bones		✓		Frequent trouble sleeping
✓			Frequent or severe headache		✓		Tumor, growth, cyst, cancer		✓		Depression or excessive worry
✓			Dizziness or fainting spells		✓		Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Ear, nose, or throat trouble		✓		Frequent or painful urination		✓		Periods of unconsciousness
	✓		Hearing loss		✓		Bed wetting since age 12		✓		Have you ever had homosexual contact?
	✓		Chronic or frequent colds		✓		Kidney stone or blood in urine		✓		
	✓		Severe tooth or gum trouble		✓		Sugar or albumin in urine		✓		Been exposed to AIDS
✓			Sinusitis		✓		VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
	✓		Hay Fever		✓		Recent gain or loss of weight		✓		Drug Use/Addiction
	✓		Head injury		✓		Arthritis, Rheumatism, or Bursitis		✓		Marijuana
	✓		Skin diseases		✓		Bone, joint or other deformity		✓		Cocaine
	✓		Thyroid trouble		✓		Lameness		✓		Heroin
	✓		Tuberculosis		✓		Loss of finger or toe		✓		L.S.D.
✓	✓		Asthma		✓		Painful or "Trick" shoulder or elbow		✓		Amphetamines
✓	✓		Shortness of breath		✓		Recurrent back pain		✓		Others: (Specify)
✓	✓		Pain or pressure in chest		✓		"Trick" or locked knee				
✓			Chronic cough		✓		Foot trouble		✓		Alcohol or drug Withdrawal Problems
	✓		Palpitation or pounding heart		✓		Neuritis				
	✓		Heart trouble		✓		Paralysis (include infantile)				
	✓		High or low blood pressure								
	✓		Cramps in your legs								
	✓		Frequent indigestion								
	✓		Stomach, liver, or intestinal trouble								
	✓		Gall bladder trouble or gallstones								
	✓		Jaundice or hepatitis								

10. FEMALES ONLY HAVE YOU EVER

			Been treated for a female disorder
			Had a change in menstrual pattern
			ARE YOU PREGNANT
			SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

GENERAL MOTORS COPERATION

12. ARE YOU (Check one) ✗

☑ Right handed ☐ Left handed

000113

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.	✓		19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.			
		D. Other medical reasons *(If yes, give reasons.)*		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
		16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
	✓	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13–22 ABOVE)

O

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE Darryl Baker

SIGNATURE Darryl Baker

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED, WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? no

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ____

GENERAL POPULATION ✓ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION ____

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

DRUG ALLERGIES NKDA

MEDICATIONS 0

MEDICAL PROBLEMS ② orbital Fx plus engaged c ophthalmology.

INFEC. DISEASE 0

LICE 0

SUICIDAL IDEATIONS 0

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
[illegible] JULES, M.D. FDC BROOKLYN	7/6/04	[illegible]-C	

REVERSE

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
[illegible] CARL [illegible] DAVID	19613-039
3. PURPOSE OF EXAMINATION	**4. DATE OF EXAMINATION** / **5. EXAMINING FACILITY**
Intake Screen	10/18/95 — FCI McKean

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

33 4.0. ♂ EKM — no med.

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever
	✓		Rheumatic fever
	✓		Swollen or painful joints
	✓		Frequent or severe headache
	✓		Dizziness or fainting spells
	✓		Eye trouble
	✓		Ear, nose, or throat trouble
	✓		Hearing loss
	✓		Chronic or frequent colds
	✓		Severe tooth or gum trouble
	✓		Sinusitis
	✓		Hay Fever
	✓		Head injury
	✓		Skin diseases
	✓		Thyroid trouble
	✓		Tuberculosis
	✓		Asthma
	✓		Shortness of breath
	✓		Pain or pressure in chest
	✓		Chronic cough
	✓		Palpitation or pounding heart
	✓		Heart trouble
	✓		High or low blood pressure
	✓		Cramps in your legs
	✓		Frequent indigestion
	✓		Stomach, liver, or intestinal trouble
	✓		Gall bladder trouble or gallstones
	✓		Jaundice or hepatitis
	✓		Adverse reaction to serum drug or medicine
	✓		Broken bones
	✓		Tumor, growth, cyst, cancer
	✓		Rupture/hernia
	✓		Piles or rectal disease
	✓		Frequent or painful urination
	✓		Bed wetting since age 12
	✓		Kidney stone or blood in urine
	✓		Sugar or albumin in urine
	✓		VD—Syphilis, gonorrhea, etc.
	✓		Recent gain or loss of weight
	✓		Arthritis, Rheumatism, or Bursitis
	✓		Bone, joint or other deformity
	✓		Lameness
	✓		Loss of finger or toe
	✓		Painful or "Trick" shoulder or elbow
	✓		Recurrent back pain
	✓		"Trick" or locked knee
	✓		Foot trouble
	✓		Neuritis
	✓		Paralysis (include infantile)
	✓		Epilepsy or fits
	✓		Car, train, sea or air sickness
	✓		Frequent trouble sleeping
	✓		Depression or excessive worry
	✓		Loss of memory or amnesia
	✓		Nervous trouble of any sort
	✓		Periods of unconsciousness
	✓		Have you ever had homosexual contact?
	✓		Been exposed to AIDS
	✓		Alcohol Use (Excessive)
	✓		Drug Use/Addiction
	✓		Marijuana — Hx
	✓		Cocaine — Hx
	✓		Heroin
	✓		L.S.D.
	✓		Amphetamines
			Others: (Specify)
	✓		Alcohol or drug Withdrawal Problems

10. FEMALES ONLY HAVE YOU EVER

	Been treated for a female disorder
	Had a change in menstrual pattern
	ARE YOU PREGNANT
	SUSPECT YOU ARE PREGNANT

WHAT IS YOUR USUAL OCCUPATION?

ASSEMBLY MAN

12. ARE YOU (Check one)

☑ Right handed ☐ Left handed

LVN

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason for rejections.)*
		D. Other medical reasons *(If yes, give reasons.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			
	✓	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
	✓	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13–22 ABOVE)

Medications	✓ No	___ Yes
Allergies	✓ No	___ Yes
Medical Complaints	✓ No	___ Yes
Evidence of Lice	✓ No	___ Yes
Hx of IV Drug Use	✓ No	___ Yes
Suicidal Throughts	✓ No	___ Yes

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: DARRYL ORRIN BAKER

SIGNATURE: Darryl Baker

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ___ TRANSFER ✓ P.V. ___

OTHER ___

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? NA

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ___ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? NA

DUTY STATUS: TEMPORARY WORK ___ RESTRICTED ___

GENERAL POPULATION ✓ YES ___ NO ___

TYPE AND EXTENT OF LIMITATION ___

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

POLY SUBSTANCE ABUSE

EDM –

CHRONIC LBP

7/7/00 Reviewed : Bzjct DR C

DO YOU HAVE

Frequent Colds	✓ No	___ Yes
Thrush	✓ No	___ Yes
Night Sweats	✓ No	___ Yes
Diarrhea	✓ No	___ Yes
Skin Rashes	✓ No	___ Yes

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Mark Peoria, PA-C D. K. PEL, FMG PA	30 JUN 2000 10/18/95	USP LEWISBURG HEALTH SERVICES U LEWISBURG, PA 17837	

000116

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
B[illegible] O. D[illegible]	19613-039

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Intake Screening	10-4-95	FDC - [illegible]

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

Good health

No meds

7. HAVE YOU EVER *(Please check each item)*

YES	NO	*(Check each item)*
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	*(Check each item)*
	✓	Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*
	✓		Scarlet fever		✓		Adverse reaction to serum drug or medicine		✓		Epilepsy or fits
	✓		Rheumatic fever						✓		Car, train, sea or air sickness
	✓		Swollen or painful joints		✓		Broken bones		✓		Frequent trouble sleeping
	✓		Frequent or severe headache		✓		Tumor, growth, cyst, cancer		✓		Depression or excessive worry
	✓		Dizziness or fainting spells		✓		Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Ear, nose, or throat trouble		✓		Frequent or painful urination		✓		Periods of unconsciousness
	✓		Hearing loss		✓		Bed wetting since age 12		✓		Have you ever had homosexual contact?
	✓		Chronic or frequent colds		✓		Kidney stone or blood in urine				
	✓		Severe tooth or gum trouble		✓		Sugar or albumin in urine		✓		Been exposed to AIDS
	✓		Sinusitis		✓		VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
	✓		Hay Fever		✓		Recent gain or loss of weight	✓			Drug Use/Addiction
	✓		Head injury		✓		Arthritis, Rheumatism, or Bursitis	✓			Marijuana
	✓		Skin diseases		✓		Bone, joint or other deformity	✓			Cocaine
	✓		Thyroid trouble		✓		Lameness		✓		Heroin
	✓		Tuberculosis		✓		Loss of finger or toe		✓		L.S.D.
	✓		Asthma		✓		Painful or "Trick"shoulder or elbow		✓		Amphetamines
	✓		Shortness of breath		✓		Recurrent back pain				Others: (Specify)
	✓		Pain or pressure in chest		✓		"Trick" or locked knee				
	✓		Chronic cough		✓		Foot trouble		✓		Alcohol or drug Withdrawal Problems
	✓		Palpitation or pounding heart		✓		Neuritis				
	✓		Heart trouble		✓		Paralysis (include infantile)				
	✓		High or low blood pressure								
	✓		Cramps in your legs								
	✓		Frequent indigestion								
	✓		Stomach, liver, or intestinal trouble								
	✓		Gall bladder trouble or gallstones								
	✓		Jaundice or hepatitis								

10. FEMALES ONLY HAVE YOU EVER

YES	NO	DON'T KNOW	
			Been treated for a female disorder
			Had a change in menstrual pattern
			ARE YOU PREGNANT
			SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)
☒ Right handed ☐ Left handed

000117

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.			
		D. Other medical reasons *(If yes, give reasons.)*		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
DB WB	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	✓	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
	✓	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13-22 ABOVE)

Treatment Program 4 of the

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: Daniel O. Opat

SIGNATURE: Daniel Opat

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE

THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? N/A

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? PE scheduled

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ✓

GENERAL POPULATION ✓ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION none

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

33 y/o, BM, NKA, Non smoker
Hx of Drug abuse

000118

TYPED OR PRINTED NAME OF EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
MARIO BAYONETO, PA	10-4-5	PA	

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY PORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
OAKAR DARRIL ORRIN	19613-039
3. PURPOSE OF EXAMINATION	**4. DATE OF EXAMINATION**	**5. EXAMINING FACILITY**
Physical R&D athelete	6/8/95	F.B.C. MICAH

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

(1) NO MEDS
(2) HEALTHY

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
	✓	Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to serum drug		✓		Epilepsy or fits
	✓		Rheumatic fever		✓		or medicine		✓		Car, train, sea or air sickness
	✓		Swollen or painful joints		✓		Broken bones		✓		Frequent trouble sleeping
	✓		Frequent or severe headache		✓		Tumor, growth, cyst, cancer		✓		Depression or excessive worry
	✓		Dizziness or fainting spells		✓		Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Ear, nose, or throat trouble		✓		Frequent or painful urination		✓		Periods of unconsciousness
	✓		Hearing loss		✓		Bed wetting since age 12		✓		Have you ever had
	✓		Chronic or frequent colds		✓		Kidney stone or blood in urine				homosexual contact?
	✓		Severe tooth or gum trouble		✓		Sugar or albumin in urine		✓		Been exposed to AIDS
	✓		Sinusitis		✓		VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
	✓		Hay Fever		✓		Recent gain or loss of weight		✓	✓	~~Drug Use/Addiction~~
	✓		Head injury		✓		Arthritis, Rheumatism, or Bursitis			✓	Marijuana
	✓		Skin diseases		✓		Bone, joint or other deformity			✓	Cocaine
	✓		Thyroid trouble		✓		Lameness				Heroin
	✓		Tuberculosis		✓		Loss of finger or toe				L.S.D.
	✓		Asthma		✓		Painful or "Trick"shoulder or elbow				Amphetamines
	✓		Shortness of breath		✓		Recurrent back pain				Others: (Specify)
	✓		Pain or pressure in chest		✓		"Trick" or locked knee				
	✓		Chronic cough		✓		Foot trouble				Alcohol or drug
	✓		Palpitation or pounding heart		✓		Neuritis				Withdrawal Problems
	✓		Heart trouble		✓		Paralysis (include infantile)				
	✓		High or low blood pressure								
	✓		Cramps in your legs					10. FEMALES ONLY HAVE YOU EVER			
	✓		Frequent indigestion								Been treated for a female disorder
	✓		Stomach, liver, or intestinal trouble								Had a change in menstrual pattern
	✓		Gall bladder trouble or gallstones								ARE YOU PREGNANT
	✓		Jaundice or hepatitis								SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?
F-M Truck + Bus

12. ARE YOU (Check one)
☑ Right handed ☐ Left handed

000119

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	✓	D. Other medical reasons *(If yes, give reasons.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
✓		14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			
	✓	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
✓		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13–22 ABOVE)

Treatment Center Insight
Treatment Center Turning Point

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: Darryl Baker

SIGNATURE: Darryl Baker

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? P.E. scheduled

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ✓

GENERAL POPULATION ✓ YES ____ NO

TYPE AND EXTENT OF LIMITATION needs P.E.

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

32 BM
NKA
Polysubstance abuse

000120

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
STEPHEN GIDEL, PA PHYSICIAN ASSISTANT	6/8/05	Stephen Gidel P.A	

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
[illegible]	08/26/05	1230

Inmate's Name	Register Number
Baker, Darryl	19613-039

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☑ yes; ☐ no (Explain)
136/86

2. General Population Housing Approved? ☑ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☑ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☑ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☑ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks: advised to follow up 8/29/05 S/C to discuss Tegr

Medical Staff Signature	Date	Time
S. Gosa PA-C	08/26/05	1320

Medical Staff Title Samuel Gosa, PA-C
USP [illegible]burg

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

BP-S354.060 **INTAKE SCREENI (MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
	8-12-04	1500

Inmate's Name	Register Number
Baker, Darryl	19613-039

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☑ yes; ☐ no (Explain)

2. General Population Housing Approved? ☑ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☑ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
G Bullock PA	8-12-04	1500

Medical Staff Title Gary Bullock
Physician Assistant

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

P-E354.060
DV 94

INTAKE SCREENING (MEDICAL)

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

MEDICAL STAFF SHALL COMPLETE THIS SCREENING FORM ON ALL ARRIVALS TO THE INSTITUTION

Institution	Date of Arrival	Time of Arrival
MPE BMD		

Name of Inmate	Register Number
Baker, Darryl	19613-039

MEDICAL CLEARANCE

BP-149 (60) reviewed? ☑ Yes ☐ No	Explain
General Population Housing Approved? ☑ Yes ☐ No	Specify limitation or need
Approved for Temporary Work Assignment? ☑ Yes ☐ No	Specify limitation or exclusion
For Holdovers: OK for Continued Transportation? ☑ Yes ☐ No	Explain
Disabilities? ☐ Yes ☑ No	If yes, enter code(s) into MDS)

Remarks

Medical Staff Signature	Medical Staff Title	
Y. HERCULES, PA-C MDC BROOKLYN	PA-C	
	Date: 7/26/04	Time: 2040

Record Copy - Inmate Central File; Copy - File

000123

Replaces BP-354(60) of APRIL 90 and BP-S354 of AUG 94

BP-S304.052 INTAKE SCREENING (MEDICAL) CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
USP LEWISBURG Health Services Unit Lewisburg, PA 17837	7-1-04	1400

Inmate's Name	Register Number
Baker, Darryl	19613-039

MEDICAL CLEARENCE

1. BP-149(60) reviewed? X yes; ☐ no (Explain)

2. General Population Housing Approved? X yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? X yes; ☐ no Specify limitations or exclusions

No Food Service work until Medically cleared.

4. For Holdovers: OK for Continued Transport? X yes; ☐ no Explain)

5. Disabilities? ☐ yes X no (If yes, enter code s into MDS)
Code(s):

6. Remarks:

Medical Staff Signature	Date	Time
	7-1-04	1448

Medical Staff Title
D. McClintock; Paramedic *L. Potter; Paramedic*

B. Prince; Paramedic *R. Parkyn; Paramedic*

000124

Record Copy - Inmate Central File; Copy - File
(This form may be replicated via WP) Replaces BP-S304.052 dtd APR 94 and BP-S304.05 dtd AUG 82

BP-S354.060 INTAKE SCREENING (MEDICAL) CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
Kane	7/2/02	

Inmate's Name	Register Number
Baker, Darryl	19615-039

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☐ no (Specify limitations or exclusions) Pending

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:
Ethm
40 w/ Oc

Medical Staff Signature	Date	Time
Theresa Saunders PA	7/2/02	1220

Medical Staff Title
PA

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

000125

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
USP Lewisburg PA	6/30/02	1205

Inmate's Name	Register Number
Baker, Darryl	19613-039

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☐ yes; ☒ no (Specify limitation or need)

H/O

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS) Code(s)

6. Remarks: none

Medical Staff Signature	Date	Time
[signature]	6/30/02	1228

Medical Staff Title: Ivan Navarro, PA

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990 and BP-S354 of AUG 1994

000126

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
FCI Loretto	7/7/00	

Inmate's Name	Register Number
Baker, Darryl	19613-039

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☒ no (Specify limitations or exclusions)

Pending Clearance

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

NO LICE ⊘ SUICIDAL IDEATION

Medical Staff Signature	Date	Time
[signature] PA C	7/7/00	1225

Medical Staff Title

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

000127

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
USP LEWISBURG HEALTH SERVICES UNIT LEWISBURG, PA 17837	30 JUN 2000	1930

Inmate's Name	Register Number
BAKER, DANIEL	~~Left~~ 19613-039

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

o

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks: NONE

Medical Staff Signature	Date	Time
NO Lice Mark Peoria, PA-C	30 JUN 2000 7/7/00	1613 1222

Medical Staff Title

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

000128

BP-S354.060 **INTAKE SCREENI...** (MEDICAL) CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
McKean	10/18/95	

Inmate's Name	Register Number
Baker, Darryl	19613-039

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s):

6. Remarks:
EKM.

Medical Staff Signature	Date	Time
	10/18/95	1730

Medical Staff Title

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INTAKE SCREE. .NG *(MEDICAL)*

(Medical staff shall complete this screening form on all arrivals to the institution)

INSTITUTION	DATE OF ARRIVAL	TIME OF ARRIVAL
FDC - Milan	10-4-95	1200

INMATE'S NAME	REGISTER NUMBER
Baker, Darryl	19613-039

MEDICAL CLEARANCE

[1] BP-149(60) REVIEWED? ☐ YES ☑ NO *(Explain):*

not available

[2] General Population Housing Approved? ☑ YES ☐ NO *(Specify limitation or need):*

[3] Approved for Temporary Work Assignment? ☐ YES ☑ NO *(Specify limitations or exclusions):*

Asthma pt

[4] For Holdovers: OK for Continued Transport? ☑ YES ☐ NO *(Explain):*

[5] Remarks:

Asthma pt

MEDICAL STAFF SIGNATURE	DATE
MARIO BAYONETO, PA	10-4-95
MEDICAL STAFF TITLE	**TIME**
PA	1325

ORIGINAL - INMATE CENTRAL FILE
CANARY - FILE

000130

USP LVN

BP-354(60)
APRIL 1990

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INTAKE SCREE NG *(MEDICAL)*

(Medical staff shall complete this screening form on all arrivals to the institution)

INSTITUTION	DATE OF ARRIVAL	TIME OF ARRIVAL
F.D.C. MIAMI	6/8/95	1200

INMATE'S NAME	REGISTER NUMBER
BAKER, DARRYL	19613-039

MEDICAL CLEARANCE

[1] BP-149(60) REVIEWED? ☐ YES ☑ NO *(Explain):* Medical

[2] General Population Housing Approved? ☑ YES ☐ NO *(Specify limitation or need):*

[3] Approved for Temporary Work Assignment? ☐ YES ☑ NO *(Specify limitations or exclusions):*

[4] For Holdovers: OK for Continued Transport? ☑ YES ☐ NO *(Explain):*

[5] Remarks: Ethnic NKMg

MEDICAL STAFF SIGNATURE	DATE
[signature]	6/8/95
MEDICAL STAFF TITLE	**TIME**
P.A	1525

ORIGINAL - INMATE CENTRAL FILE
CANARY - FILE

000131

USP LVN

BP-354(60)
APRIL 1990

513-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET** 330 (332-2118)

REQUEST

TO: ophthamalogy (orbital surgeon) | FROM: *(Requesting physician or activity)* ROSS QUINN, M.D. MEDICAL OFFICER Dr Keller | DATE OF REQUEST 5-18-05

REASON FOR REQUEST *(Complaints and findings)* UK

Hx (L) orbit fracture / CT scan result 3-28-05 orbits 3-28-05 head (R)

PROVISIONAL DIAGNOSIS

(L) inferior rectus / diplopia

DOCTOR'S SIGNATURE ROSS QUINN, M.D. MEDICAL OFFICER | APPROVED mgk MC | PLACE OF CONSULTATION ☐ BEDSIDE ☒ ON CALL | ☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY 30-60 days

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO | PATIENT EXAMINED ☐ YES ☐ NO | TELEMEDICINE ☐ YES ☐ NO

Approved for ophthalmology cons-lt re necessity of surgical intervention of ? entrapment (L) rectus muscle - 60-90 days

ROSS QUINN, M.D.
MEDICAL OFFICER
JUN 08 2005

(Continue on reverse side)

SIGNATURE AND TITLE | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME *(Last, first, middle)* | SPONSOR'S ID NUMBER *(SSN or Other)* FSL ELKTON

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade)* | REGISTER NO. | WARD NO.

Baker, Darryl 19613039
6-3062

CONSULTATION SHEET
Medical Record 000132

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO:	FROM: *(Requesting physician or activity)*	DATE OF REQUEST
opthamalogist	Dr Keller	1-19-05

REASON FOR REQUEST *(Complaints and findings)*

(VR)

(L) eye 2° HA

PROVISIONAL DIAGNOSIS

Diplopia, Dizziness 2° to Assault. (Send Hx consults)

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
	o	☐ BEDSIDE ☑ ON CALL	☑ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE	DATE

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT
	FSL Feltman	

RELATION TO SPONSOR	SPONSOR'S NAME *(Last, first, middle)*	SPONSOR'S ID NUMBER *(SSN or Other)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade)*	REGISTER NO.	WARD NO.
Baker, Daryl 1961 3-039		

CONSULTATION SHEET

Medical Record 000133

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

513-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Radiology - CAT Scan

FROM: *(Requesting physician or activity)*

DATE OF REQUEST: 09/20/04

REASON FOR REQUEST *(Complaints and findings)*

Inmate i assa-lt → (L) orbital fracture & sx (L) ocular entrapment. Need CAT scan orbit, adm (L) to F/u fx & prepare for probable surgery

PROVISIONAL DIAGNOSIS

As Above

DOCTOR'S SIGNATURE

APPROVED mm

PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME *(Last, first, middle)* | SPONSOR'S ID NUMBER *(SSN or other)* FSL ELKTON

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name–last, first, middle; ID no. (SSN or other); Sex; Date of Birth: Rank/Grade)* | REGISTER NO. | WARD NO.

Baker, Daryl
19613-039
06/30/62

CONSULTATION SHEET
Medical Record
STANDARD FORM 513 (REV. 4-98) 000134
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)